WASHTENAW COMMUNITY COLLEGE
Office of Human Resource Management

Independent Staff, OPT
Non Bargained OPT & Custodial Maintenance

Request for College Provided Reimbursement
(Dental, Vision & Health Club Dues)
Employee Use Only

Employee ID: @_____

Employee Name:_____
Last First M.I.

Position: _____

Department: _____

Amount of reimbursement: $ _____

I hereby certify that on (date)_____, I received and paid the attached bill(s) from (provider's name) _____

_____

_____ _____
Employee's Signature ***Date***

Notes: _____

_____

_____

Services must be rendered between 7/1 and 6/30 (fiscal year).

All form(s) & supporting document(s) must be in HRM no later than 07/15.

Human Resource Use Only

Processed to Payroll by: _____

Date: _____

Total cost of services: _____

Reimbursement: _____